Exhibit 2a

BP-S620.060 **PATIENT PROBLEM LIST** CDFRM
AUG 96

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

PROBLEM LIST

DATE NOTED	SIGNIFICANT DIAGNOSES	SIGNIFICANT OPERATIONS/ INVASIVE PROCEDURES	DATE
7/16/97	NIDDM - Tx'd	(R) Hand Fx + Sx	1992

Date: 11/15/04

Care Level: 1 ✓ 2 __ 3 __ 4 __

Clinical Director D. Marini, MD DMarini

COPY

ADVERSE / ALLERGIC DRUG REACTIONS
(If none, record "No Known Drug Allergies)

NKDA

Patient Identification
(Name, Reg #, DOB)

BROWN
DEMETRIUS 21534-039
B/M/O/02-08-1972
HT/509 WT/170 HR/BK EY/BN
CUSTODY/IN

form may be replicated via WP)

000001

11/12

PROBLEM LIST (Continued)

DATE NOTED	SIGNIFICANT DIAGNOSES	SIGNIFICANT OPERATIONS/ INVASIVE PROCEDURES	DATE

Patient identification
(Name, Reg #, DOB)

BP-S619.060 **IMMUNIZATION RECORD** CDFRM
AUG 96
U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

TETANUS TOXOIDS

DATE	MFG'R	LOT #	EXP. DATE	SITE	DOSE/ ROUTE	PROVIDER	INSTITUTION
7/16/97	Connaught	7D9611	4/17/97	(L) Deltoid	0.5cc/IM	Nurten	FCI McKean

TUBERCULIN TESTS

DATE GIVEN	MFG'R	LOT #	EXP. DATE	SITE	DOSE/ ROUTE	PROVIDER/ INSTITUTION	DATE READ	RESULTS (MM)	READ BY
7/16/97	Connaught	2434-1	2/1/98	(L) forearm	0.1cc/ID	Nurten/FCI McK	7/18/97	0x0	Geary
7-8-98	Connaught	2486-11	10-99	(R) FA	5TU ID	C. Rymer, RN FCI McKean	7-10-98	0x0	Geary
7/7/99	Connaught	2493-11	1/12/00	(R) FA	5TU ID	C. Rymer RN FCI McKean	7/9/99	0x0	Geary
7/11/00	Connaught	C0149AA	9/17/00	(R) FA	5TU ID	C. Rymer RN FCI McKean	7/13/00	0x0	Geary
07/07/01	Connaught	C0630AA	5/15/02	(L) FA	0.1cc ID	C. Lundberg RN FCI McKean	7/11/01	0x0	
7/9/02	Aventis	C094AB	3/16/04	(L) FA	0.1cc ID	[illegible]	7/11/02	0x0	
7/8/03	Aventis	0852P	9/03	(L) FA	0.1cc ID	[illegible]	7-10-03	0x0	
6/29/04	Aventis	0015AP	08/05	LT. Arm	0.1cc ID	McKean	7/1/04	0	
6/27/03	Aventis	C2114AB	6/1/07	(L) FA	0.1cc ID	Liberty/RBK	6/29/04	0	EA

COPY

Patient Identification
(Name, Reg #)

BROWN
DEMETRIUS 21534-039
B/M/O/02-08-1972
HT/509 WT/170 HR/BK EY/BN
CUSTODY/IN

Form may be replicated via WP)

HEPATITIS VACCINE

DATE	MFG'R	LOT #	EXP. DATE	SITE	DOSE/ ROUTE	PROVIDER	INSTITUTION

INFLUENZA VACCINE

DATE	MFG'R	LOT #	EXP. DATE	SITE	DOSE/ ROUTE	PROVIDER	INSTITUTION

OTHER (MMR, Polio, etc)

DATE	TYPE	MFG'R	LOT #	EXP. DATE	SITE	DOSE/ ROUTE	PROVIDER/ INSTITUTION

Patient Identification
(Name, Reg #)

MEDICAL RECORD — REPORT OF MEDICAL EXAMINATION

DATE OF EXAM: 6/25/13

1. LAST NAME–FIRST NAME–MIDDLE NAME: Brown Demetrius
2. IDENTIFICATION NUMBER: 21534-039
3. GRADE AND COMPONENT OR POSITION:
4. HOME ADDRESS (Number, street or RFD, city or town, state and ZIP code): 16134 Greenview Detroit, MI. 48219
5. EMERGENCY CONTACT (Name and address of contact): AL Brannan 24329 Leewin Detroit, MI. 48209
6. DATE OF BIRTH: 2/8/72
7. AGE: 31
8. SEX: ☐ FEMALE ☒ MALE
9. RELATIONSHIP OF CONTACT: DAD
10. PLACE OF BIRTH: Detroit, MI.
11. RACE: ☐ WHITE ☒ BLACK ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ HISPANIC WHITE ☐ HISPANIC BLACK ☐ ASIAN/PACIFIC ISLANDER
12a. AGENCY: BOPDOJ
12b. ORGANIZATION UNIT: FCI McKean
13. TOTAL YEARS GOVERNMENT SERVICE: a. MILITARY: b. CIVILIAN:
14. NAME OF EXAMINING FACILITY OR EXAMINER, AND ADDRESS: P.O. Box 5000 Bradford, PA 16701
15. RATING OR SPECIALTY OF EXAMINER:
16. PURPOSE OF EXAMINATION: Bi Annually

17. CLINICAL EVALUATION

NORMAL	(Check each item in appropriate column, enter "NE" if not evaluated.)	ABNORMAL
✓	A. HEAD, FACE, NECK AND SCALP	
✓	B. EARS-GENERAL (INTERNAL CANALS) Scant Cerumen (Auditory acuity under items 39 and 40)	
✓	C. DRUMS (Perforation) TMs dull & fld.	
✓	D. NOSE ⊕ DNS – RT	
✓	E. SINUSES	
✓	F. MOUTH AND THROAT ⊕ Tonsils it Smooth	
✓	G. EYES-GENERAL (Visual acuity and refraction under items 28, 29, and 36)	
✓	H. OPHTHALMOSCOPIC	
✓	I. PUPILS (Equality and reaction)	
✓	J. OCULAR MOTILITY (Associated parallel movements nystagmus)	
✓	K. LUNGS AND CHEST	
✓	L. HEART (Thrust, size, rhythm, sounds)	
✓	M. VASCULAR SYSTEM (Varicosities, etc.)	
✓	N. ABDOMEN AND VISCERA (Include hernia)	
N/E	O. PROSTATE (Over 40 or clinically indicated)	
✓	P. TESTICULAR	
N/E	Q. ANUS AND RECTUM (Hemorrhoids, Fistulae) (Hemocult Results)	
✓	R. ENDOCRINE SYSTEM	
✓	S. G-U SYSTEM	
✓	T. UPPER EXTREMITIES (Strength, range of motion)	
✓	U. FEET	
✓	V. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
✓	W. SPINE, OTHER MUSCULOSKELETAL	
✓	X. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
✓	Y. SKIN, LYMPHATICS	
✓	Z. NEUROLOGIC (Equilibrium tests under item 41)	
✓	AA. PSYCHIATRIC (Specify any personality deviation)	
✓	BB. BREASTS	
✓	CC. PELVIC (Females only)	

NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 42 and use additional sheets if necessary)

Nuh- From, ϕLA, ⊕ TMJ, ϕ Bruits

COPY

18. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)

Restorable Teeth: 1 (32) 2 (31) C 3 (30) C
Non-restorable teeth: 1 (32) 2 (31) / 3 (30) /
Missing Teeth: 1 (32) 2 (31) X 3 (30) X
Replaced by Dentures: 1 (32) X 2 (31) X 3 (30) X
Fixed Partial Dentures: 1 (32) 2 (31) X 3 (30) X

RIGHT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	LEFT
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES:

19. TEST RESULTS (Copies of results are preferred as attachments)

A. URINALYSIS: (1) SPECIFIC GRAVITY
(2) URINE ALBUMIN
(3) URINE SUGAR
(4) MICROSCOPIC
B. CHEST X-RAY OR PPD (Place, date, film number and result)
C. SYPHILIS SEROLOGY (Specify test used and results)
D. EKG
E. BLOOD TYPE AND RH FACTOR
F. OTHER TESTS

000005

MEASUREMENTS AND OTHER FINDINGS

20. HEIGHT	21. WEIGHT	22. COLOR HAIR	23. COLOR EYES	24. BUILD	25. TEMPERATURE
5'10"	170#	Black	Brown	☐ SLENDER ☑ MEDIUM ☐ HEAVY ☐ OBESE	98

26. BLOOD PRESSURE *(Arm at heart level)*

	A. SITTING	B. RECUMBENT	C. STANDING (5 mins.)
SYS.	138		
DIAS.	74		

27. PULSE *(Arm at heart level)*

A. SITTING	B. RECUMBENT	C. STANDING (3 mins.)	D. AFTER EXERCISE	E. 2 MINS. AFTER
74	RR 12			

28. DISTANT VISION 20/15 20/40

RIGHT 20/ 15	CORR. TO 20/	BY	S.	CX
LEFT 20/ 20	CORR. TO 20/	BY	S.	CX

29. REFRACTION

30. NEAR VISION

CORR. TO	BY
CORR. TO	BY

31. HETEROPHORIA *(Specify distance)*

ESO	EXO	R.H.	L.H.	PRISM DIV.	PRISM CONV. CT	PC	PD

32. ACCOMMODATION		33. COLOR VISION *(Test used and result)*	34. DEPTH PERCEPTION *(Test used and score)*	
RIGHT WL	LEFT WL	OK		UNCORRECTED
				CORRECTED

35. FIELD OF VISION		36. NIGHT VISION *(Test used and score)*	37. RED LENS TEST	38. INTRAOCULAR TENSION	
RIGHT WL	LEFT WL	WL		RIGHT	LEFT

39. HEARING			40. AUDIOMETER								41. PSYCHOLOGICAL AND PSYCHOMOTOR *(Tests used and score)*
RIGHT WV	/15 SV	/15		250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192	
LEFT WV	/15 SV	/15	RIGHT									
			LEFT									

42. NOTES *(Continued)* AND SIGNIFICANT OR INTERVAL HISTORY

- WD/WN & HM
- Dental Service – 2 wks Prior → all good & cleaning & restoration required
- PPD done 7/8/03 – Results Pending Read 7-10-03

(Use additional sheets if necessary)

43. SUMMARY OF DEFECTS AND DIAGNOSES *(List diagnoses with item numbers)*

44. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED *(Specify)*

Return PRN-Clinic & Biannual H & PE

45A. PHYSICAL PROFILE

P	U	L	H	E	S

46. EXAMINEE *(Check)*

A. ☑ IS QUALIFIED FOR

B. ☐ IS NOT QUALIFIED FOR

Regular Housing & Recreational Work

45B. PHYSICAL CATEGORY

47. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

A	B	C	E

48. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
Robert E. Piotrowski, PA-C	Robert E. Piotrowski, PA-C
49. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
50. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN *(Indicate which)* P. Olson MD Director	SIGNATURE
51. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY	SIGNATURE

MEDICAL RECORD — REPORT OF MEDICAL EXAMINATION — DATE OF EXAM 7/16/97

1. LAST NAME–FIRST NAME–MIDDLE NAME: Brown, Demetrios
2. IDENTIFICATION NUMBER: 21534-039
3. GRADE AND COMPONENT OR POSITION:
4. HOME ADDRESS (Number, street or RFD, city or town, state and ZIP code): 16134 Greenview Detroit, MI. 48219
5. EMERGENCY CONTACT (Name and address of contact): Kimberly Moore 16134 Greenview Det, MI. 48219
6. DATE OF BIRTH: 2/8/72
7. AGE: 25
8. SEX: ☐ FEMALE ☒ MALE
9. RELATIONSHIP OF CONTACT: Wife
10. PLACE OF BIRTH: Detroit
11. RACE: ☐ WHITE ☒ BLACK ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ HISPANIC WHITE ☐ HISPANIC BLACK ☐ ASIAN/PACIFIC ISLANDER
12a. AGENCY: BOP - DOJ
12b. ORGANIZATION UNIT: FCI McKean
13. TOTAL YEARS GOVERNMENT SERVICE: a. MILITARY: b. CIVILIAN:
14. NAME OF EXAMINING FACILITY OR EXAMINER, AND ADDRESS: FCI McKean Box 5000 Bradford, PA
15. RATING OR SPECIALTY OF EXAMINER:
16. PURPOSE OF EXAMINATION: A + O

17. CLINICIAL EVALUATION

NORMAL	(Check each item in appropriate column, enter "NE" if not evaluated.)	ABNORMAL	NORMAL	(Check each item in appropriate column, enter "NE" if not evaluated.)	ABNORMAL
✓	A. HEAD, FACE, NECK AND SCALP			O. PROSTATE (Over 40 or clinically indicated)	
	B. EARS-GENERAL (INTERNAL CANALS) (Auditory acuity under items 39 and 40)	✓		P. TESTICULAR } NE	
				Q. ANUS AND RECTUM (Hemorrhoids, Fistulae) (Hemocult Results)	
	C. DRUMS (Perforation)	✓	✓	R. ENDOCRINE SYSTEM	
✓	D. NOSE		✓	S. G-U SYSTEM	
✓	E. SINUSES		✓	T. UPPER EXTREMITIES (Strength, range of motion)	
✓	F. MOUTH AND THROAT		✓	U. FEET	
✓	G. EYES-GENERAL (Visual acuity and refraction under items 28, 29, and 36)		✓	V. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
✓	H. OPHTHALMOSCOPIC		✓	W. SPINE, OTHER MUSCULOSKELETAL	
✓	I. PUPILS (Equality and reaction)			X. IDENTIFYING BODY MARKS, SCARS, TATTOOS See #531	✓
✓	J. OCULAR MOTILITY (Associated parallel movements nystagmus)		✓	Y. SKIN, LYMPHATICS	
✓	K. LUNGS AND CHEST		✓	Z. NEUROLOGIC (Equilibrium tests under item 41)	
✓	L. HEART (Thrust, size, rhythm, sounds)			AA. PSYCHIATRIC (Specify any personality deviation) NE	
✓	M. VASCULAR SYSTEM (Varicosities, etc.)			BB. BREASTS	
✓	N. ABDOMEN AND VISCERA (Include hernia)			CC. PELVIC (Females only) N/A	

NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 42 and use additional sheets if necessary)

B + C impacted cerumen, TM not visualized.

COPY

18. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)

Restorable Teeth: 32 31 30 | Non-restorable teeth: X 32 31 30 | Missing Teeth: X X X / 32 31 30 | Replaced by Dentures: (X) / 32 31 30 | Fixed Partial Dentures: (X) / 32 31 30

RIGHT: 1 2 3 4 5 6 7 8 — LEFT: 9 10 11 12 13 14 15 16 / RIGHT: 32 31 30 29 28 27 26 25 — LEFT: 24 23 22 21 20 19 18 17

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

19. TEST RESULTS (Copies of results are preferred as attachments)

A. URINALYSIS. (1) SPECIFIC GRAVITY
(2) URINE ALBUMIN
(3) URINE SUGAR
(4) MICROSCOPIC
B. CHEST X-RAY OR PPD (Place, date, film number and result)
C. SYPHILIS SEROLOGY (Specify test used and results)
D. EKG
E. BLOOD TYPE AND RH FACTOR
F. OTHER TESTS

000007

BROWN, DEMETRIUS a15 34 037

MEASUREMENTS AND OTHER FINDINGS

20. HEIGHT	21. WEIGHT	22. COLOR HAIR	23. COLOR EYES	24. BUILD	25. TEMPERATURE
5'9"	174	black	brown	☐ SLENDER ☑ MEDIUM ☐ HEAVY ☐ OBESE	97.6

26. BLOOD PRESSURE (Arm at heart level)						27. PULSE (Arm at heart level)				
A. SITTING	SYS. 116 DIAS. 76	B. RECUMBENT	SYS. DIAS.	C. STANDING (5 mins.)	SYS. DIAS.	A. SITTING	B. RECUMBENT	C. STANDING (3 mins.)	D. AFTER EXERCISE	E. 2 MINS. AFTER

28. DISTANT VISION	29. REFRACTION	30. NEAR VISION
RIGHT 20/ 20 CORR. TO 20/	BY S. CX	CORR. TO BY
LEFT 20/ 20 CORR. TO 20/	BY S. CX	CORR. TO BY

31. HETEROPHORIA (Specify distance)

ESO	EXO	R.H.	L.H.	PRISM DIV.	PRISM CONV. CT	PC	PD

32. ACCOMMODATION		33. COLOR VISION (Test used and result)	34. DEPTH PERCEPTION (Test used and score)	UNCORRECTED
RIGHT	LEFT	N		CORRECTED
35. FIELD OF VISION		36. NIGHT VISION (Test used and score)	37. RED LENS TEST	38. INTRAOCULAR TENSION
RIGHT	LEFT			RIGHT LEFT

39. HEARING			40. AUDIOMETER									41. PSYCHOLOGICAL AND PSYCHOMOTOR (Tests used and score)
				250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192	
RIGHT WV	/15 SV	/15	RIGHT									
LEFT WV	/15 SV	/15	LEFT									

42. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY

1992 - Hand Fx and surgery done (R)

25 y/o, Black male
non smoker
NKDA
Hx of STD - 1991 - treated
no HIV test in the past

(Use additional sheets if necessary)

43. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item numbers)

44. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify)

45A. PHYSICAL PROFILE

P	U	L	H	E	S

46. EXAMINEE (Check)

A. ☑ IS QUALIFIED FOR Regular Duty

B. ☐ IS NOT QUALIFIED FOR

45B. PHYSICAL CATEGORY

47. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

A	B	C	E

48. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
M. TARR, MLP	
49. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
D. OLSON M D	
50. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (Specialty, if any, which)	SIGNATURE
51. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY	SIGNATURE

*U.S. Government Printing Office: 1996 - 404-763/20080

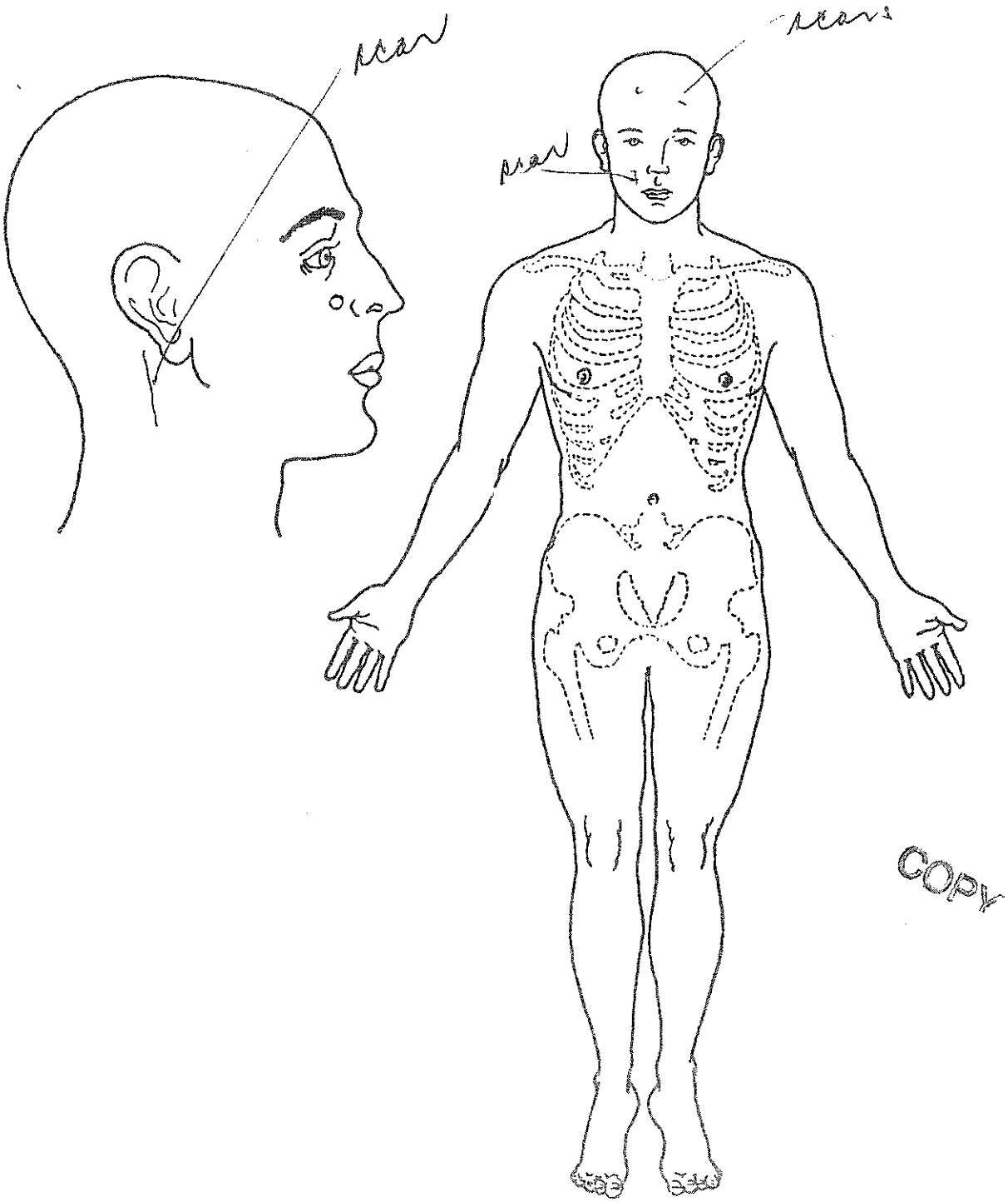
STANDARD FORM 88 (Rev. 10-94) BACK

000008

531-110

NSN 7540-00-634-4274

MEDICAL RECORD | **ANATOMICAL FIGURE**



PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility.)*

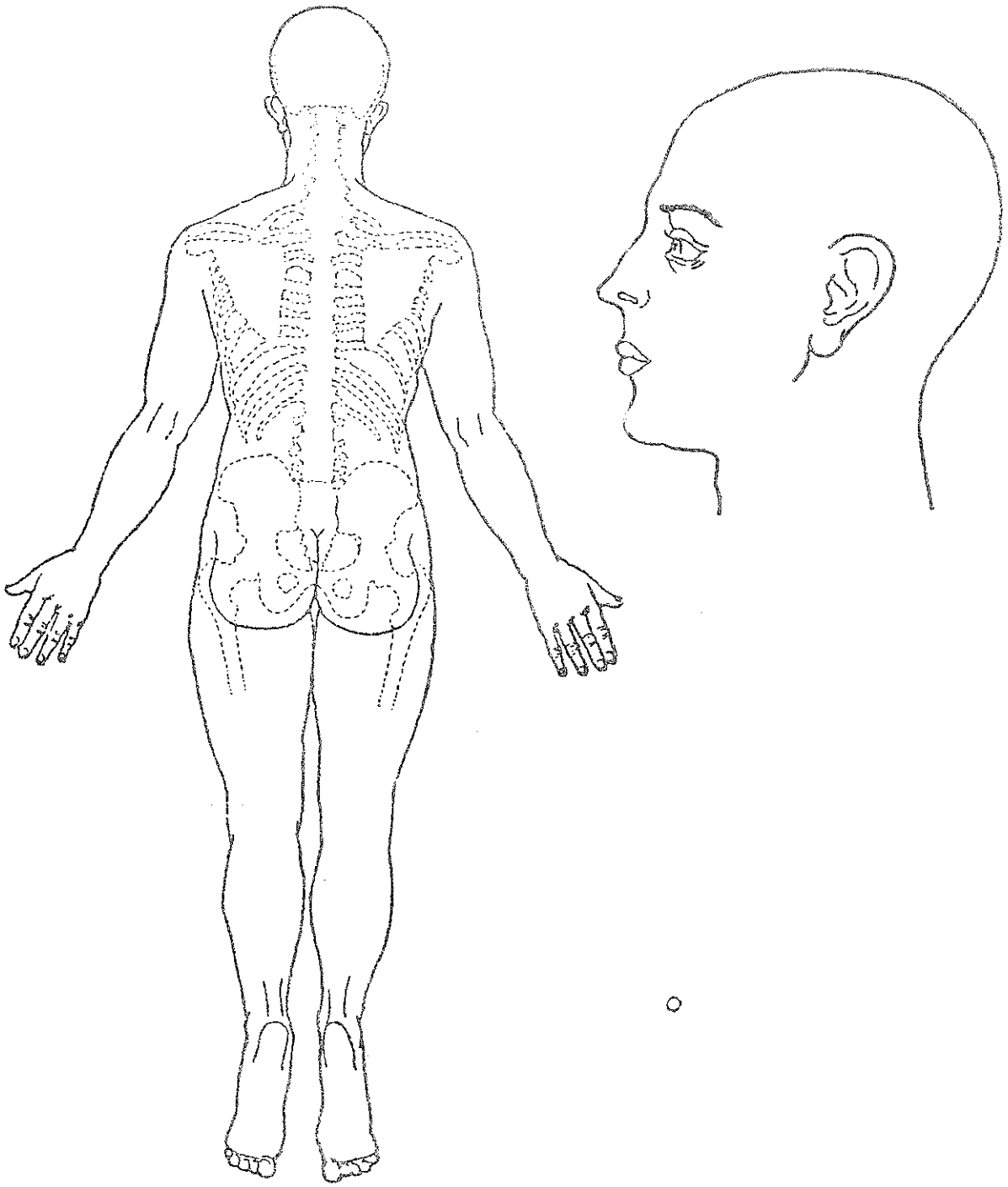
REGISTER NO. 21534-039

WARD NO.

ANATOMICAL FIGURE

000009

STANDARD FORM 531 (Rev. 4-91)
Prescribed by GSA/ICMR. FIRMR (41 CFR) 201-9.202-1



*U.S. Government Printing Office: 1992 — 312-071/50064

U.S. Department of Justice

Federal Bureau Of Prisons

MEDICAL HISTO' REPORT

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. REGISTER NUMBER	
BROWN DEMETRIUS DUANE	21534-039	
3. PURPOSE OF EXAMINATION	**4. DATE OF EXAMINATION**	**5. EXAMINING FACILITY**
INTAKE	11-4-09	FCI Raybrook

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint arises)*

No medication
NKDA
Denies pain

COPY

7. HAVE YOU EVER *(Please check each item)*

YES	NO	(Check each item)
	✓	Lived with anyone who had tuberculosis
	✓	Coughed up blood
	✓	Bled excessively after injury or tooth extraction
	✓	Attempted suicide
	✓	Been a sleepwalker

8. DO YOU *(Please check each item)*

YES	NO	(Check each item)
	✓	Wear glasses or contact lenses
	✓	Have vision in both eyes
	✓	Wear a hearing aid
	✓	Stutter or stammer habitually
	✓	Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
	✓		Scarlet fever		✓		Adverse reaction to serum drug		✓		Epilepsy or fits
	✓		Rheumatic fever		✓		or medicine		✓		Car, train, sea or air sickness
	✓		Swollen or painful joints		✓		Broken bones		✓		Frequent trouble sleeping
	✓		Frequent or severe headache		✓		Tumor, growth, cyst, cancer		✓		Depression or excessive worry
	✓		Dizziness or fainting spells		✓		Rupture/hernia		✓		Loss of memory or amnesia
	✓		Eye trouble		✓		Piles or rectal disease		✓		Nervous trouble of any sort
	✓		Ear, nose, or throat trouble		✓		Frequent or painful urination		✓		Periods of unconsciousness
	✓		Hearing loss		✓		Bed wetting since age 12				Have you ever had
	✓		Chronic or frequent colds		✓		Kidney stone or blood in urine		✓		homosexual contact?
	✓		Severe tooth or gum trouble		✓		Sugar or albumin in urine		✓		Been exposed to AIDS
	✓		Sinusitis		✓		VD—Syphilis, gonorrhea, etc.		✓		Alcohol Use (Excessive)
	✓		Hay Fever		✓		Recent gain or loss of weight		✓		Drug Use/Addiction
	✓		Head injury		✓		Arthritis, Rheumatism, or Bursitis		✓		Marijuana
	✓		Skin diseases		✓		Bone, joint or other deformity		✓		Cocaine
	✓		Thyroid trouble		✓		Lameness		✓		Heroin
	✓		Tuberculosis		✓		Loss of finger or toe		✓		L.S.D.
	✓		Asthma		✓		Painful or "Trick"shoulder or elbow		✓		Amphetamines
	✓		Shortness of breath		✓		Recurrent back pain		✓		Others: (Specify)
	✓		Pain or pressure in chest		✓		"Trick" or locked knee				
	✓		Chronic cough		✓		Foot trouble				Alcohol or drug
	✓		Palpitation or pounding heart		✓		Neuritis		✓		Withdrawal Problems
	✓		Heart trouble		✓		Paralysis (include infantile)				
	✓		High or low blood pressure								
	✓		Cramps in your legs					10. FEMALES ONLY HAVE YOU EVER			
	✓		Frequent indigestion								Been treated for a female disorder
	✓		Stomach, liver, or intestinal trouble								Had a change in menstrual pattern
	✓		Gall bladder trouble or gallstones								ARE YOU PREGNANT
	✓		Jaundice or hepatitis								SUSPECT YOU ARE PREGNANT

11. WHAT IS YOUR USUAL OCCUPATION?

12. ARE YOU (Check one) ☑ ☐

CHECK EACH ITEM YES OR NO EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW

YES	NO		YES	NO	
	✓	13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.		✓	18. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*
	✓	B. Inability to perform certain motions.		✓	19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*
	✓	C. Inability to assume certain positions.		✓	20. Have you ever been rejected for military service because of physical, mental, or other reason? *(If yes, give date, and reason, for rejections.)*
	✓	D. Other medical reasons *(If yes, give reasons.)*		✓	21. Have you ever been discharged from military service because of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)*
	✓	14. Have you, ever been treated for a mental condition? *(If yes, specify when, where, and give details).*		✓	22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? *(If yes, specify what kind, granted by whom , and what amount, when, why.)*
	✓	15. Have you ever been denied life insurance? *(If yes, state reason and give details.)*			
	✓	16. Have you had, or have you been advised to have, any operations? *(If yes, describe and give age at which occured.)*			
	✓	17. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*			

EXPLANATION: (#13–22 ABOVE)

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.

TYPED OR PRINTED NAME OF EXAMINEE

SIGNATURE Demetrius Brown

INTAKE SCREENING:

INMATE RECEIVED FROM: COURT ____ TRANSFER ____ P.V. ____

OTHER: ____

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH, HOW OFTEN, HOW USED, WHEN WERE THEY LAST USED: HAVE THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? ____

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES ____ NO ____

WHAT ARRANGEMENTS HAVE BEEN MADE? ____

DUTY STATUS: TEMPORARY WORK ____ RESTRICTED ____

GENERAL POPULATION ____ YES ____ NO ____

TYPE AND EXTENT OF LIMITATION ____

23. Physician's summary and elaboration of all pertinent data *(Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)*

neg TB

not HIV / Hepatitis tested

neg suicidal ideation

Hx VD 1994

neg tattoos

neg IVDU

neg Lice

000012

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
K BURNS RN	1/11/05		

U.S. Department of Justice
Federal Bureau Of Prisons

MEDICAL HISTORY REPORT

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. REGISTER NUMBER
Demetrius Brown A.K.A. Davis Duane Dixson	21534-039

3. PURPOSE OF EXAMINATION	4. DATE OF EXAMINATION	5. EXAMINING FACILITY
Intake Screening Federal Transfer Center, OK	JUN 19 1997	

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint arises)*

COPY

7. HAVE YOU EVER *(Please check each item)*

YES	NO	(Check each item)
	X	Lived with anyone who had tuberculosis
	X	Coughed up blood
	X	Bled excessively after injury or tooth extraction
	X	Attempted suicide
	X	Been a sleepwalker

8. DO YOU *(Please check each item)*

YES	NO	(Check each item)
	X	Wear glasses or contact lenses
	X	Have vision in both eyes
	X	Wear a hearing aid
	X	Stutter or stammer habitually
	X	Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
	X		Scarlet fever		X		Adverse reaction to serum drug		X		Epilepsy or fits
	X		Rheumatic fever		X		or medicine		X		Car, train, sea or air sickness
	X		Swollen or painful joints		X		Broken bones		X		Frequent trouble sleeping
	X		Frequent or severe headache		X		Tumor, growth, cyst, cancer		X		Depression or excessive worry
	X		Dizziness or fainting spells		X		Rupture/hernia		X		Loss of memory or amnesia
	X		Eye trouble		X		Piles or rectal disease		X		Nervous trouble of any sort
	X		Ear, nose, or throat trouble		X		Frequent or painful urination		X		Periods of unconsciousness
	X		Hearing loss				Bed wetting since age 12		X		Have you ever had homosexual contact?
	X		Chronic or frequent colds		X		Kidney stone or blood in urine				
	X		Severe tooth or gum trouble		X		Sugar or albumin in urine			X	Been exposed to AIDS
	X		Sinusitis	X			VD—Syphilis, gonorrhea, etc.	X			Alcohol Use (Excessive)
	X		Hay Fever		X		Recent gain or loss of weight		X		Drug Use/Addiction
	X		Head injury		X		Arthritis, Rheumatism, or Bursitis	X			Marijuana
	X		Skin diseases		X		Bone, joint or other deformity		X		Cocaine
	X		Thyroid trouble		X		Lameness		X		Heroin
	X		Tuberculosis		X		Loss of finger or toe		X		L.S.D.
	X		Asthma		X		Painful or "Trick"shoulder or elbow		X		Amphetamines
	X		Shortness of breath		X		Recurrent back pain		X		Others: (Specify)
	X		Pain or pressure in chest		X		"Trick" or locked knee				
	X		Chronic cough		X		Foot trouble		X		Alcohol or drug Withdrawal Problems
	X		Palpitation or pounding heart		X		Neuritis				
	X		Heart trouble		X		Paralysis (include infantile)				
	X		High or low blood pressure								
	X		Cramps in your legs					10. FEMALES ONLY HAVE YOU EVER			
	X		Frequent indigestion								Been treated for a female disorder
	X		Stomach, liver, or intestinal trouble								Had a change in menstrual pattern
	X		Gall bladder trouble or gallstones								ARE YOU PREGNANT
	X		Jaundice or hepatitis								SUSPECT YOU ARE PREGNANT

11. WHAT IS YOUR USUAL OCCUPATION?

12. ARE YOU (Check one)
☒ Right handed ☐ Left handed

000013

CHECK EACH ITEM YES — IF EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW

YES	NO		YES	NO	
	X	13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.		X	18. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*
	X	B. Inability to perform certain motions.		X	19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*
	X	C. Inability to assume certain positions.		X	
	X	D. Other medical reasons *(If yes, give reasons.)*		X	20. Have you ever been rejected for military service because of physical, mental, or other reason? *(If yes, give date, and reason, for rejections.)*
	X	14. Have you, ever been treated for a mental condition? *(If yes, specify when, where, and give details).*		X	21. Have you ever been discharged from military service because of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)*
	X	15. Have you ever been denied life insurance? *(If yes, state reason and give details.)*		X	
	X	16. Have you had, or have you been advised to have, any operations? *(If yes, describe and give age at which occured.)*		X	22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? *(If yes, specify what kind, granted by whom , and what amount, when, why.)*
X		17. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*		X	

EXPLANATION: (#13–22 ABOVE)

I was a patient at Grace Hospital in Detroit due to a Head Injury and a Head Fracture.

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.

TYPED OR PRINTED NAME OF EXAMINEE: Demetrius Brown

SIGNATURE: Demetrius Brown

INTAKE SCREENING:

INMATE RECEIVED FROM: COURT ____ TRANSFER X P.V. ____

OTHER ____

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH, HOW OFTEN, HOW USED. WHEN WERE THEY LAST USED: HAVE THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? No

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES ____ NO X

WHAT ARRANGEMENTS HAVE BEEN MADE? ____

DUTY STATUS: TEMPORARY WORK ____ RESTRICTED ____

GENERAL POPULATION ____ YES ____ NO ____

TYPE AND EXTENT OF LIMITATION ____

23. Physician's summary and elaboration of all pertinent data *(Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)*

NKDA

000014

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
Russell Rooms NR EMT-P Federal Transfer Center, OK	JUN 19		

Federal Bureau Of Prisons

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. REGISTER NUMBER
Brown Demetrius	21534-039

3. PURPOSE OF EXAMINATION	4. DATE OF EXAMINATION	5. EXAMINING
1/S	06/30/97	USP LEWISBURG HEALTH SERVICES UNIT LEWISBURG, PA 17837

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint arises)*

COPY

7. HAVE YOU EVER *(Please check each item)*

YES	NO	(Check each item)
	✓	Lived with anyone who had tuberculosis
	✓	Coughed up blood
	✓	Bled excessively after injury or tooth extraction
	✓	Attempted suicide
	✓	Been a sleepwalker

8. DO YOU *(Please check each item)*

YES	NO	(Check each item)
	✓	Wear glasses or contact lenses
✓		Have vision in both eyes
	✓	Wear a hearing aid
	✓	Stutter or stammer habitually
	✓	Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
	✓		Scarlet fever				Adverse reaction to serum drug				Epilepsy or fits
	✓		Rheumatic fever				or medicine				Car, train, sea or air sickness
			Swollen or painful joints				Broken bones				Frequent trouble sleeping
			Frequent or severe headache			✓	Tumor, growth, cyst, cancer				Depression or excessive worry
			Dizziness or fainting spells				Rupture/hernia				Loss of memory or amnesia
			Eye trouble				Piles or rectal disease				Nervous trouble of any sort
			Ear, nose, or throat trouble				Frequent or painful urination				Periods of unconsciousness
			Hearing loss				Bed wetting since age 12				Have you ever had
			Chronic or frequent colds				Kidney stone or blood in urine				homosexual contact?
			Severe tooth or gum trouble				Sugar or albumin in urine			✓	Been exposed to AIDS
			Sinusitis	✓			VD—Syphilis, gonorrhea, etc.				Alcohol Use (Excessive)
			Hay Fever				Recent gain or loss of weight				Drug Use/Addiction
			Head injury				Arthritis, Rheumatism, or Bursitis	✓			Marijuana
			Skin diseases				Bone, joint or other deformity				Cocaine
			Thyroid trouble				Lameness				Heroin
			Tuberculosis				Loss of finger or toe				L.S.D.
			Asthma				Painful or "Trick"shoulder or elbow				Amphetamines
			Shortness of breath				Recurrent back pain				Others: (Specify)
			Pain or pressure in chest				"Trick" or locked knee				
			Chronic cough				Foot trouble				Alcohol or Drug
			Palpitation or pounding heart				Neuritis				Withdrawal Problems
			Heart trouble				Paralysis (include infantile)				
			High or low blood pressure								
			Cramps in your legs					10. FEMALES ONLY HAVE YOU EVER			
			Frequent indigestion								Been treated for a female disorder
			Stomach, liver, or intestinal trouble								Had a change in menstrual pattern
			Gall bladder trouble or gallstones								ARE YOU PREGNANT
			Jaundice or hepatitis								SUSPECT YOU ARE PREGNANT

11. WHAT IS YOUR USUAL OCCUPATION?

12. ARE YOU (Check one)
☑ Right handed ☐ Left handed

000015

BP-360(60)
JANUARY 1986

CHECK EACH ITEM YE — NO EVERY ITEM CHECKED YES MUST BE FULLY — AINED IN BLANK SPACE BELOW

YES	NO		YES	NO	
	✓	13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.		✓	18. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*
	✓	B. Inability to perform certain motions.		✓	19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*
	✓	C. Inability to assume certain positions.		✓	20. Have you ever been rejected for military service because of physical, mental, or other reason? *(If yes, give date, and reason, for rejections.)*
	✓	D. Other medical reasons *(If yes, give reasons.)*		✓	21. Have you ever been discharged from military service because of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)*
	✓	14. Have you, ever been treated for a mental condition? *(If yes, specify when, where, and give details).*		✓	22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? *(If yes, specify what kind, granted by whom, and what amount, when, why.)*
	✓	15. Have you ever been denied life insurance? *(If yes, state reason and give details.)*			
	✓	16. Have you had, or have you been advised to have, any operations? *(If yes, describe and give age at which occured.)*			
✓		17. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*			

EXPLANATION: (#13–22 ABOVE) 1992 Detroit Grace Hosp. Head fracture RH.

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.

TYPED OR PRINTED NAME OF EXAMINEE: Demetrius Brown

SIGNATURE: Demetrius Brown

INTAKE SCREENING:

INMATE RECEIVED FROM: COURT ___ TRANSFER ✓ P.V. ___

OTHER ___

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH, HOW OFTEN, HOW USED, WHEN WERE THEY LAST USED: HAVE THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? NO

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES ___ NO ✓

WHAT ARRANGEMENTS HAVE BEEN MADE? NONE

DUTY STATUS: TEMPORARY WORK ___ RESTRICTED NO

GENERAL POPULATION ___ YES ___ NO

TYPE AND EXTENT OF LIMITATION NO

23. Physician's summary and elaboration of all pertinent data *(Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)*

Medications	___ Yes	✓ No
Allergies	___ Yes	✓ No
Medical Complaints	___ Yes	✓ No
Evidence of Lice	___ Yes	✓ No
Hx of IV Drug Use	___ Yes	✓ No
Suicidal Thoughts	___ Yes	✓ No

Im Request no pork diet.

000016

TYPED OR PRINTED NAME AND TITLE OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
Platin Hilletework, PA	06/30/97		

REVERSE

SN 7540-00-634-4176 600-108

HEALTH RECORD — CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3/2/05 0930	ANNUAL FOOD HANDLER'S EXAMINATION
	S) Any symptoms or history of:
	1: Acute or chronic inflammatory conditions of the respiratory system (active TB, cough, etc)? ☐ Yes ☒ No
	2: Acute or chronic infections, skin diseases, open sores? ☐ Yes ☒ No
	3: Acute or chronic intestinal infections (diarrhea, etc.)? ☐ Yes ☒ No
	4: Any communicable diseases (HIV, Hepatitis B, Hepatitis C, etc.)? ☐ Yes ☒ No
	Explain any yes answer to the above questions:
	O) Blood Pressure: 110/78 Pulse: 60 Wt 190 Temp: 96
	Pertinent, exam including: ENT, lungs, heart, abdomen and skin. WNL
	A) Healthy male
	P) (Cleared) / Not Cleared for Food Service work.

D. Marini, M.D.
Clinical Director

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

RECORDS MAINTAINED AT:

PATIENT'S NAME *(Last, First, Middle Initial)*: Brown Demetrius — SEX:

RELATIONSHIP TO SPONSOR — STATUS — RANK/GRADE

SPONSOR'S NAME — ORGANIZATION

DEPART./SERVICE — SSN/IDENTIFICATION NO.: 21534-039 — PATIENT NO.: 000017

FEDERAL CORRECTIONAL INSTITUTION
PO BOX 300
RAY BROOK, NEW YORK 12977-0300

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR

DATE | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Date each entry)

10/25/05
1400

S c/o cold on ↑ l.p x 1 week. and hyperpigmentation
(R) zygomatic area of face p "blackhead burst"
O 24yo AA ♂ NAD
(R) zygomatic area brown hyperpigmentation
. c distinct edges. No raised area, no acne noted. (Will pt to monitor)
Hsv 1 c center cleft l.p ≈ right sup to cleft healing, flat papule ∅ drainage ≤ 0.5mm fleshy colored
A Hsv 1
Hyperpigmentation lesion
P Education - above — E. HUGHES, APRN, BC-FNP

PRN

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
11-15-04 1035	BP-149 RECEIVED AND REVIEWED AT FCI, RAY BROOK, NY ON 11-4-04 SKieffer S. Kieffer, MRT DM D. Marini, M.D. Clinical Director
3/11 05 1035	(S) Staph exposure. (-) pain / open wounds or sores (O) No wounds present (A) s/p staph exposure (P) No tx needed F/u if any type of wound forms educated to pt. Bradley R. Cink, PA-C
3.1.05 1034	SCHEDULED FOR 7/5 Physical per request 3/2/04 0920 T. Root, Med. Secretary T. Root Med. Secretary

HOSPITAL OR MEDICAL FACILITY | STATUS | DEPART./SERVICE | RECORDS MAINTAINED AT

SPONSOR'S NAME | SSN/ID NO. | RELATIONSHIP TO SPONSOR

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

Brown, Demetrius

REGISTER NO. 21534-039 | WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE

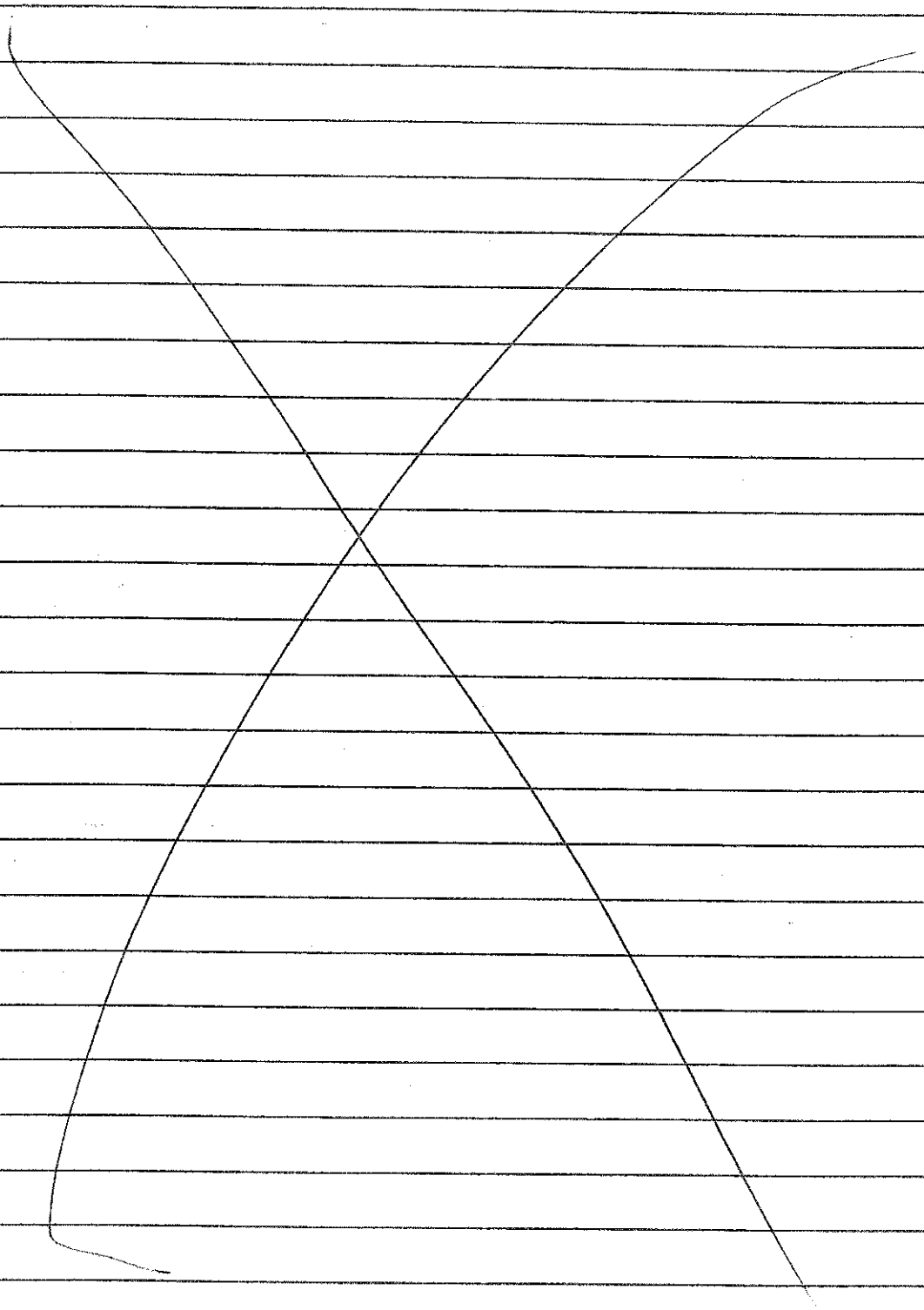
Medical Record 000019

FEDERAL CORRECTIONAL INSTITUTION
PO BOX 300
RAY BROOK, NY 12977

STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

USP LVN

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*



NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7/9/03 0820hrs	31 y/o AA o/g Bi annual H&P VS: 138/74, 74, 12 & 98.2 F Denies c/o or S/S since last H&P 7/10/97 See Form 9 Pg R. E. Piotrowski, PA-C Robert E. Piotrowski, PA-C FCI McKean
7/9/03 0820hrs	Admin. Note — PPD done 7/8/03 Resulting Pending Read. 7/10/03 R. E. Piotrowski, PA-C Robert E. Piotrowski, PA-C FCI McKean

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
			FCI McKean
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO. 21534-039 | WARD NO.

Brown, Demetrius 21534-039

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-00) 000021
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*